State of California—Health and Human Services Agency
Department of Health Care Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Dear Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. Please complete the enclosed Medi-Cal provider enrollment application package and return it to the Department of Health Care Services, Provider Enrollment Division, MS 4704, P.O. Box 997413, Sacramento, California, 95899-7413.

Please read all the instructions included in the application package carefully and complete each item requested. Incomplete application packages will be returned.

PLEASE NOTE: Applicants and providers are required to submit their National Provider Identifier (NPI) with each Medi-Cal provider application package. Applicants are required to attach a copy of the CMS/National Plan and Provider Enumeration System (NPPES) confirmation for each NPI listed in the application package. If providers are not eligible to receive an NPI, they should instead enter the word "atypical" in any NPI fields. These "atypical providers" will receive a unique Medi-Cal provider number once the application is approved.

It is your responsibility to report to the DHCS any modifications to information previously submitted within 35 days from the date of the change. Most changes may be reported on a *Medi-Cal Supplemental Changes* (DHCS 6209, rev. 2/08) form. However, you must complete a new application package if you are reporting a change of ownership of 50 percent or more, a change of business address, or one of the other changes identified in Title 22, California Code of Regulations (CCR), Section 51000.30, subsections (a) through (b).

If you are planning to sell your business or buy an existing business, you may find it helpful to refer to the Medi-Cal Provider Enrollment page at **www.medi-cal.ca.gov**. The Provider Enrollment page contains information about enrollment options available to you whenever there is a sale or purchase of a Medi-Cal enrolled provider or business, including the option to submit a *Successor Liability with Joint and Several Liability Agreement*.

Enrollment forms are available at **www.medi-cal.ca.gov** or by contacting the Telephone Service Center at 1-800-541-5555. For more information about the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our Web site at **www.medi-cal.ca.gov** and click the “Provider Enrollment” link.

If you have any additional enrollment questions, please contact the Provider Enrollment Message Center at (916) 323-1945, or submit your question(s) to the address above or via email at **PEDCorr@dhcs.ca.gov**. In order to submit claims electronically, providers must request a submitter number by completing the *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHCS 6153, rev. 12/07*),* available on the Medi-Cal Web site at **www.medi-cal.ca.gov** by clicking the "Forms" link in the "Featured" area, then "Billing."

Provider Enrollment Division

Enclosures (Revised 2/08)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL MEDICAL TRANSPORTATION PROVIDER APPLICATION

DO NOT USE staples on this form or on any attachments.
DO NOT USE correction tape, white out, or highlighter pen or ink of a similar type on this form. If you must make corrections, please line through, date, and initial in ink.
DO NOT LEAVE any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

This form is part of an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers must also provide additional information and documentation. Applicants and providers may be subject to an on-site inspection and to unannounced visits prior to enrollment or approval for continued enrollment in a program. In addition to this form and requested documentation, a MEDI-CAL DISCLOSURE STATEMENT (DHCS 6207) and a MEDI-CAL PROVIDER AGREEMENT (DHCS 6208) must also be completed for enrollment or continued enrollment. Additional information can be found on the Medi-Cal Web site (www.medi-cal.ca.gov) by clicking the "Provider Enrollment" link.

Omission of any information or documentation on this form or the failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations (CCR), Section 51000.50.

You must attach copies of Centers for Medicare and Medicaid Services/National Plan and Provider Enumeration System (CMS/NPPES) confirmation for each National Provider Identifier (NPI) submitted with your application package. You may not submit an NPI for use in Medi-Cal billing unless that NPI is appropriately registered with CMS and is in compliance with all NPI requirements established by CMS at the time of submission.

Enrollment action requested—check all that apply. Enter the date you are completing the application.

"New provider"—check if the applicant is not currently enrolled in the Medi-Cal program as a provider with an active provider number. Include the current National Provider Identifier (NPI) for the business address indicated in item 4.

"Change of business address"—check if the applicant is currently enrolled in the Medi-Cal program and is requesting to relocate to a new business address and vacate the old location. Indicate the business address applicant is moving from.

"Additional business address"—check if the applicant is currently enrolled in the Medi-Cal program and is requesting enrollment for an additional business location.

"New Taxpayer ID Number"—check if a new Taxpayer Identification Number (TIN) was issued by the IRS.

"Change of ownership"—check if there is a change of ownership as defined in Title 22, CCR, Section 51000.6. Indicate the effective date in the space provided. Indicate the effective date in the space provided.

"Cumulative change of 50 percent or more in person(s) with ownership or control interest"—check if there is a cumulative change of 50 percent or more in the person(s) with an ownership or control interest, as defined in Title 22, CCR, Section 51000.15, since the information provided in the last complete application package that was approved for enrollment. Indicate the effective date in the space provided.

"Sale of assets (50 percent or more)"—check if 50 percent or more of the assets owned by the corporation, at the location for which a provider number has been issued, are sold or transferred. Indicate the effective date in the space provided.

"Continued Enrollment"—check if the applicant is currently enrolled as a Medi-Cal provider and has been requested by the Department to apply for continued enrollment in the Medi-Cal program. Do not check this box unless you have received notification from the Department, pursuant to Title 22, CCR, Section 51000.55. List current provider number(s).

Check the box labeled "I intend to use my current . . . ." if you intend to use your current provider number to bill for services delivered at this location while this application request is pending. This action places the provider on provisional provider status, pursuant to Title 22, CCR, Section 51000.51.

"Type of entity"—check the box which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, you must attach a legible copy of the partnership agreement. If you check "other", list the type of legal entity.

"Type of transportation"—check all that apply.

"Specific mode of transportation"—check all that apply.

1. "Legal name" is the name listed with the Internal Revenue Service (IRS).
2. "Business name" is the name of the applicant or provider if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement/Permit number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement to the application.
3. "Business telephone number" is the primary business telephone number used at the business address. A beeper number, cell phone, answering service, pager, facsimile machine, biller or billing service, or answering machine shall not be used as the primary business telephone.
4. "Business address" is the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.
5. "Pay-to address" is the address at which the applicant or provider wishes to receive payment. The pay-to-address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.

6. "Mailing address" is the location at which the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
7. "Previous business address" is the address where the applicant or provider was previous enrolled. If the applicant or provider is not submitting an application for a change of location, enter N/A.
8. Enter each taxonomy code(s) associated with your NPI. Attach additional sheet(s) if needed.
9. Enter the Taxpayer Identification Number (TIN) issued by the IRS under the name of the applicant or provider. Attach a legible copy of IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification).
10. If the business is a sole proprietorship not using a TIN, provide the social security number of the sole proprietor. (See Privacy Statement on page 6)
11. Enter any NPI for the business address indicated in item 4, registered with other carriers including, but not limited to Medicare. Attach a copy of the CMS/NPPES confirmation for each.
12. "Hours of operation" are business days and hours that the applicant or provider is available for service to Medi-Cal beneficiaries.
13. Check the appropriate box to indicate whether you have Worker's Compensation insurance as required by state law. If applicable, attach proof. If not applicable, check N/A and provide an explanation.
14. "Geographic area(s) served" are those areas in which you will be transporting Medi-Cal beneficiaries. Attach a copy of the city/county business license/permit to the application. If the city/county does not require a license/permit, you must attach a letter from that city/county confirming licensing/permit requirement with the application. It is the applicant's or provider's responsibility to verify with the city/county in which transportation services will be provided for vehicle and driver's permits. If you intend to conduct business in either the City of Los Angeles or the City of San Diego, you must apply for their vehicle and driver's permits. For more information, contact either the City of Los Angeles Department of Transportation or the San Diego Metropolitan Transit Development Board.
15. Provide the following information and attach legible copies if applicable:

    Ambulance:
    - ❒ Certificate number issued by the California Highway Patrol (CHP)—attach a legible copy of CHP certificates (301 and 360A) to the application
    - ❒ Issue date
    - ❒ Vehicle Identification Number (VIN) of each vehicle that will be used to transport beneficiaries
    - ❒ Make and model of vehicle
    - ❒ Year of vehicle
    - ❒ License plate number of vehicle
    - ❒ EMS verification—attach a legible copy of EMS certificate to the application

    Driver information:
    - ❒ Full legal name of driver
    - ❒ Driver's license number and expiration date—attach a legible copy of license to the application
    - ❒ Ambulance Driver Certificate number—attach a legible copy to the application
16. Provide the following information and attach legible copies if applicable:
    - ❒ Certificate number issued by the Federal Aviation Administration (FAA)—attach a legible copy of the certificate to the application
    - ❒ Name and address where the aircraft is hangared—This statement must also be on your company letterhead and be attached to the application
    - ❒ EMS verification—attach a legible copy of EMS certificate to the application

    Pilot information:
    - ❒ Full legal name of pilot
    - ❒ Pilot's license number—the number issued by the FAA on the pilot's license of the individual named
    - ❒ Driver's license number and expiration date—attach a legible copy of license to the application
17. Provide the following information and attach legible copies if applicable:

    Litter and/or wheelchair van:
    - ❒ VIN of each vehicle that will be used to transport beneficiaries—attach a legible copy of the DMV registration to the application
    - ❒ Photographs of vehicle (i.e., view of inside, back exit door, side exit door, and view of business name)
    - ❒ Make and model of vehicle
    - ❒ Year of vehicle
    - ❒ License plate number of vehicle
    - ❒ Brake and Lamp Certificate
    - ❒ Proof of vehicle insurance
    - ❒ Special vehicle permit (if applicable)

    Driver:
    - ❒ Full legal name of driver
    - ❒ Driver's license number and expiration date—attach a legible copy of license to the application
    - ❒ DMV driving history printout for each driver
    - ❒ Certificates for first aid and CPR for each driver
    - ❒ DMV DL-51 form signed by a physician for each driver
    - ❒ Standard pre-employment drug and alcohol tests lab results for each driver

18. “Printed name of provider”—print first, middle, and last name of the provider as the sole proprietor, partner, corporate officer, or government official when applying to the Department for enrollment or continued enrollment as a provider in the Medi-Cal program.

19. Check the gender of the individual named in number 18.

20. Enter the driver’s license or state-issued identification number and state of issuance of the individual named in number 18. Attach a legible copy.

21. Enter the date of birth of the individual named in number 18.

22. Provide the social security number of individual named in number 18. (Optional, see Privacy Statement on page 6)

23. An original signature is required of the individual named in number 18. Enter the title of the person signing the application; include city, state, and date where and when the application was signed. **See Title 22, CCR Section 51000.30(a)(2)(B) to determine whether you have the authority to sign this application.**

24. Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If it must be notarized, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

25. To assist in the timely processing of the application package, enter the name, e-mail address, and telephone number of the individual who can be contacted by Provider Enrollment staff to answer questions regarding the application package. Failure to include this information may result in the application package being returned deficient for item(s) that an applicant can readily provide by fax or telephone.

✓ Remember to attach a legible copy of current documentation, if applicable:

- ❒ Fictitious Business Name Statement/Permit
- ❒ TIN verification
- ❒ CHP certificates (301 and 360A)
- ❒ DMV commercial vehicle registration
- ❒ Proof of insurance
- ❒ Brake and Lamp Certificate
- ❒ FAA certificate
- ❒ FAA Pilot’s License for each pilot
- ❒ Driver’s license for each driver
- ❒ Certificates for first aid and CPR for each driver
- ❒ DMV DL-51 form signed by a physician for each driver
- ❒ Standard pre-employment drug and alcohol tests lab results for each driver
- ❒ Ambulance Driver Certificate
- ❒ DMV driving history printout for each driver
- ❒ City/county business license/certificate
- ❒ Driver’s license or state-issued identification card of person signing the application
- ❒ Verification of Emergency Medical Services (EMS)
- ❒ Photographs of litter and/or wheelchair van (i.e., view of inside, back exit door, side exit door, and view of business name)
- ❒ Signed Medi-Cal Provider Agreement (DHCS 6208)
- ❒ Signed Medi-Cal Disclosure Statement (DHCS 6207)
- ❒ Medicare enrollment verification
- ❒ Successor Liability Agreement (if applicable)
- ❒ National Provider Identifier verification (CMS/NPPES confirmation)

MEDI-CAL MEDICAL TRANSPORTATION PROVIDER APPLICATION

Important:
- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: Department of Health Care Services
  Provider Enrollment Division
  MS 4704
  P.O. Box 997413
  Sacramento, CA 95899-7413
  (916) 323-1945

- ***Do not use* staples on this form or on any attachments.**
- ***Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.***

FOR STATE USE ONLY

Current provider number (NPI): _____

Date / /

Enrollment action requested **(check all that apply)**

- ❒ New provider
- ❒ Change of business address **(see item 6.a. below)**
- ❒ Additional business address
- ❒ New Taxpayer ID number
- ❒ *Change of ownership (per Title 22, CCR, Section 51000.6)
- ❒ *Cumulative change of 50 percent or more in person(s) with ownership or control interest (per Title 22, CCR, Section 51000.15)
- ❒ *Sale of assets (50 percent or more, per Title 22, CCR, Section 51000.30)

For items marked with * indicate the effective date: ____/___/_____

- ❒ Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, CCR, Section 51000.55.)
- ❒ I intend to use my current provider number to bill for services delivered at this location while this application request is pending. I understand that I will be on provisional provider status during this time, pursuant to Title 22, CCR, Section 51000.51.

* **A provider agreement may not be transferred or assigned to another. However, an applicant may be joined to the provider agreement by strict compliance with the provisions of Title 22, CCR, Section 51000.32 entitled "Requirements for Successor Liability with Joint & Several Liability."**

Indicate the change of ownership effective date: ___/___/____.

Type of entity (check one)

- ❒ Sole proprietor
- ❒ Corporation:
  Corporate number: _____
  State incorporated: _____
- ❒ Partnership (attach legible copy of agreement)
- ❒ Limited liability company (LLC):
  LLC number: _____
  State registered/filed:_____
- ❒ Government entity
- ❒ Nonprofit corporation
  Type of nonprofit: _____
- ❒ Other: _____

Type of transportation

- ❒ Emergency
- ❒ Both
- ❒ Nonemergency

Specific mode of transportation (check all that apply)

- ❒ Helicopter
- ❒ Fixed-wing
- ❒ Wheelchair van
- ❒ Both wheelchair and litter van
- ❒ Litter van
- ❒ Ambulance

1. Legal name of applicant or provider (as listed with the IRS)

2. Business name, if different

3. Business telephone number ( )

Is this a fictitious business name? ❒ Yes ❒ No

If yes, list the Fictitious Business Name Statement/Permit number

Effective date / /

(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit.)

4. Business address (number, street)	City	County	State	Nine-digit ZIP code
5. Pay-to address (number, street, P.O. Box number)	City		State	Nine-digit ZIP code
6. Mailing address (number, street, P.O. Box number)	City		State	Nine-digit ZIP code

For a change of business address, enter location moving <u>from:</u>

7. Previous business address (number, street)	City	State	Nine-digit ZIP code

8. Primary Taxonomy Code	Taxonomy Code	Taxonomy Code

9. Taxpayer Identification Number (TIN) (attach a legible copy of the IRS form)	10. Social security number—if sole proprietor not using a TIN, you must disclose this number (See Privacy Statement on page 6.)
___ ___ – ___ ___ ___ ___ ___ ___ ___	___ ___ ___ – ___ ___ – ___ ___ ___ ___

11. Medicare/Other NPI (See instructions)	12. Business days and hours of operation:
	Days: _____ Hours: _____

13. Does the applicant have Worker's Compensation insurance as required by state law? ❒ Yes ❒ No ❒ N/A

If applicable, attach proof of maintenance of Worker's Compensation insurance. If not applicable, check N/A and provide an explanation:

_____

14. Geographic area(s) served (list county(ies), including each city served, and attach copy(ies) of business tax permit(s)/license(s))

_____ _____

_____ _____

_____ _____

_____ _____

15. Ambulance and Driver Information—see *instructions* (attach separate sheet, if necessary)

Ambulance Information

CHP Certificate Number	Issue Date	Vehicle Identification Number(s)	Make and Model of Vehicle(s)	Year	License Number
	/ /				
	/ /				
	/ /				

Ensure legible copies of the following documents for each ambulance are attached to the application:

❒ CHP 301 certificate ❒ EMS Certificate, local ❒ CHP 360A Ambulance license

Driver Information

Legal Name	Ambulance Driver's Certificate Number	California Driver's License Number	Expiration Date
			/ /
			/ /

Ensure legible copies of the following documents for each driver are attached to the application:

❒ Ambulance Driver Certificate ❒ California Driver's License

16. Aircraft and Pilot Information—*see instructions* (attach a separate sheet, if necessary)

Aircraft Information

FAA Certificate Number	Name and Address Where Aircraft is Hangared

Ensure legible copies of the following documents for each aircraft are attached to the application:

❒ FAA Certificate ❒ EMS Certificate ❒ Statement on company letterhead of where aircraft is hangared

Pilot Information

Legal Name	Pilot's License Number	California Driver's License Number	Expiration Date
			/ /
			/ /

Ensure legible copies of the following documents for each pilot are attached to the application:

❒ FAA Pilot's License ❒ California Driver's License

17. Litter and/or Wheelchair Van/Driver Information—*see instructions* (attach a separate sheet, if necessary)

Litter and/or Wheelchair Van Information

Vehicle Identification Number(s)	Make and Model of Vehicle(s)	Year	License Number

Ensure legible copies of the following documents for each vehicle are attached to the application:

❒ DMV vehicle registration ❒ Proof of vehicle insurance ❒ Brake and Lamp Certificate ❒ Special vehicle permit (if applicable)

Driver Information

Legal Name	California Driver's License Number	Expiration Date
		/ /
		/ /
		/ /

Ensure legible copies of the following documents for each driver are attached to the application:

❒ DMV driving record printout ❒ California Driver's License ❒ DMV DL-51 form signed by a physician
❒ Certificates for first aid and CPR ❒ Special driver permit (if applicable)
❒ Standard pre-employment drug test (which lists the drugs tested for) and alcohol test lab results

Information About Individual Signing This Application

18. Printed name of provider (last) (first) (middle)

19. Gender ❒ Male ❒ Female

20. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

21. Date of birth / /

22. Social security number (***Optional***—see Privacy Statement below.) ___ ___ ___ – ___ ___ – ___ ___ ___ ___

23. **I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider pursuant to Title 22, CCR Section 51000.30(a)(2)(B).**

Signature of provider	Title

Executed at: _____, _____ on _____
(City) (State) (Date)

24. Notary Public— Please see instructions under number 24 for who must have their application signed by a Notary Public in the form specified by Section 1189 of the Civil Code.

25. **Contact Person's Information**

❒ Check here if you are the same person identified in item 18. If you checked the box, provide only the e-mail address and telephone number below.

Contact Person's Name (last) (first) (middle) (gender) ❒ Male ❒ Female

Title/Position	E-mail address	Telephone number
		( )

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Care Services, Provider Enrollment Division, by the authority of Welfare and Institutions Code Section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Division at (916) 323-1945.